Dr. Elizabeth S. Pittman, D.M.D.
FINANCIAL POLICY AGREEMENT

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies.

Patients with Insurance
If you have insurance, we will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

Patients with no Insurance
Full payment is expected on the day of service.

Treatment Plans
Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Composite Restorations
We provide composite (tooth colored) restorations. Your insurance carrier may only pay for amalgam (silver) restorations, therefore you are responsible for the amount not covered by your insurance carrier and this amount is due at the time of service.

Broken Appointments
We reserve the right to charge $50.00 for appointments cancelled or broken without 24 hours notice. This charge must be paid before another appointment can be scheduled. Arriving 15 minutes or more after your scheduled appointment could result in rescheduling your appointment and a broken appointment charge.

Returned Checks
Returned checks will be subject to a $30.00 service fee and charges for any bank fees. This must be paid along with the amount of the check within 10 days or will be turned over to the Fayette County Attorney's Office for collection.

Statement of Services
Statement of Services is due upon receipt. We consider an account delinquent after 30 days, and may be assessed a $5.00 per month service charge. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, $100.00 administrative fee, etc.

Payment Plan Option
We accept Care Credit.

Assignment and Release of Information
I assign the benefits from my insurance carrier to Elizabeth S. Pittman D.M.D. for the dental benefits I am entitled for any services furnished to me. I authorize Elizabeth S. Pittman D.M.D. to release to my insurance carrier any information needed to determine benefits for my care.

Authorization
I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

Please print the name of the patient: _____

Signature of patient (or responsible party, if patient is a minor or has a legal guardian): _____

Date: _____